

Arizona Department of Administration

ADOA Benefit Options 2018 Benefit Guide

Retired Employees



ARIZONA
DEPARTMENT OF ADMINISTRATION
BENEFITS

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Purpose of This Guide

This guide describes the comprehensive benefits package “Benefit Options” offered by the State of Arizona, Department of Administration Benefit Services Division effective January 1, 2018. Included in this reference guide are explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts.

This guide is intended to help you understand your benefits, covering specific benefits programs or essential information. We encourage you to review all your options before making your benefit elections. Additional information specific to active, retiree, or COBRA enrollees is available in specially marked sections.

The actual benefits available to you and the descriptions of these benefits are governed in all cases by the Section 125, relevant plan descriptions, and insurance contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefits plans at any time.

For more detailed information, please refer to your plan descriptions. If you need additional information, please visit our website at benefitoptions.az.gov or call us at 602-542-5008 or toll free at 1-800-304-3687.

Eligibility

Retirees

The following persons are eligible to participate in the Benefit Options Plan:

- A. Retirees receiving a pension under a state-sponsored retirement plan and continuing enrollment in the Retiree health and/or dental plan.
- B. Long-Term Disability (LTD) participants collecting benefits under a state-sponsored plan.
- C. Eligible former elected officials and their qualified dependents if the elected official has at least five years of credited service in the Elected Officials Retirement Plan; was covered under a group health or accident plan at the time of leaving office; served as an elected official on or after January 1, 1983; and applies for enrollment within 31 days of leaving office or retiring.
- D. Surviving spouse and qualified dependent provided they were covered at the time of the retiree's death.
- E. Surviving spouse of former elected official provided they were covered at the time of the official's death.
- F. Surviving spouse or surviving dependent of an active member that is eligible to retire provided they were covered at the time of the employee's death.
- G. Surviving spouse or surviving dependent of a deceased law enforcement officer killed on the line of duty as referenced in A.R.S. § 38-1114.

Eligibility Rules

As an eligible retiree, if you elected ADOA's medical or dental insurance, you may make changes to your plan(s) during Open Enrollment or changes consistent with a Qualified Life Event (QLE).

If you have declined or cancelled ADOA's medical and/or dental coverage in the past, but have maintained either coverage through ADOA, you may re-elect medical and/or dental coverage during an Open Enrollment period.

Dependents

The following dependents may be added to your plans:

- A. Your legal spouse
- B. Your child defined as:
 - a. A natural child, adopted child, step child, foster child, a child whom there is court-ordered guardianship or a child with a court order pending adoption who is younger than age 26.
 - b. Your child who is disabled and continues to be disabled as defined by 42 U.S.C. 1382c before the age of 26.

If you have a qualified dependent that is not currently enrolled in the Benefit Options Plan, he or she may be added during an Open Enrollment period. Dependents not enrolled during Open Enrollment cannot be added until the next Open Enrollment unless there is a QLE. You have 31 days from the date of the QLE to change your enrollment through ADOA Benefit Services Division. The change must be consistent with the event. Please refer to the Benefit Services website, benefitoptions.az.gov, for more information about QLEs.

Qualified Medical Child Support Order (QMCSO)

You may not terminate coverage for a dependent covered by a QMCSO.

Dependent Documentation Requirements

Proper documentation may be required after enrollment of a dependent if:

- Your dependent child is approaching age 26 and has a disability. Application for continuation of dependent status must be made within 31 days of the child's 26th birthday. You will need to provide verification that your dependent child has a qualifying permanent disability, which occurred prior to his or her 26th birthday, in accordance with 42 U.S.C. 1382c.
- You are enrolling a dependent whose last name is different from your own, the dependent's coverage will not be processed until supporting documentation such as a marriage license for a spouse, or a birth certificate or court order for a dependent, is provided to the ADOA Benefit Services Division.

Please refer to the Summary Plan Document for a complete list of eligible and ineligible dependents and eligibility requirements.

Members are required to provide Social Security Numbers (SSN) for all dependents enrolled in the Benefit Options medical plans. This requirement is in accordance with the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) which was effective January 1, 2009.

Qualified Life Events

You may only change your benefit elections when you experience a Qualified Life Event (QLE). If you have not experienced a QLE, you must wait until the next open enrollment period to make benefit changes. Events that may be considered include but are not limited to:

- Changes in your marital status: marriage, divorce, legal separation, annulment, death of spouse.
- Changes in dependent status: birth, adoption, placement for adoption, guardianship, death, or dependent eligibility due to age.
- Changes in employment status or work schedule that affect benefits eligibility for you, your spouse, and/or dependents.

Submitting a Change Request

Requested benefit changes must be submitted in writing to the Benefit Services Division within 31 calendar days of the event.

Effective Date of the Change

The effective date of coverage beginning or ending depends on the type of event following the date the requested change and required documentation is submitted to ADOA- Benefit Services Division.

The effective date for benefit changes based on all other QLEs is the first day of the next calendar month, following the date the retiree submits the requested change, along with required documentation, in writing, to ADOA Benefit Services Division.

Effective the first day of the month after completion of the enrollment process	Effective the date of birth, adoption, or court order	Effective the date of the event
<ul style="list-style-type: none">•Marriage•Divorce, annulment, or legal separation•Employment status change	<ul style="list-style-type: none">•Newborn•Adopted Child•Guardianship	<ul style="list-style-type: none">•Death of dependent•Return from Military Leave

Please consult with Benefit Services to determine whether or not the life event you are experiencing qualifies under the regulations. Any change in premiums due to a QLE will be in effect the first of the month following the receipt of all QLE documentation.

New Retiree's Option of Life Insurance Continuation

As a new retiring State of Arizona employee, you have the option of continuing all or a portion of your Life Insurance coverage with The Hartford. There are two options for continuation of coverage:

- Converting your group Life coverage to your own individual policy.
- Porting your Life coverage which continues as a term life policy. To be eligible for portability, you must terminate employment prior to Social Security Normal Retirement Age.

To apply for Conversion or Portability, you must apply within 31 days of the termination of your Life Insurance or within 15 days of the date you receive the COBRA notification. For questions or to apply, call The Hartford at 1.877.320.0484.

Dual Coverage

If you and your spouse are both State employees and/or retirees, dual coverage of an employee, spouse and dependent, is not permitted under this Plan. An employee may elect coverage for their entire family, including the State employee spouse, or each State employee spouse may elect their own coverage.

You cannot enroll as a single subscriber and be enrolled as a dependent on your spouse's policy simultaneously. If an individual is enrolled in this manner, the dual coverage will be terminated and no refunds will be made for the premiums paid.

End-Stage Renal Disease

If you are eligible to enroll in Medicare as an active employee or retiree because of End-Stage Renal Disease, the Plan will pay for the first 30 months, whether or not you are enrolled in Medicare and have a Medicare card. At the end of the 30 months, Medicare becomes the primary payer. If a plan member who is eligible for Medicare Part B does not enroll in Medicare Part B, the plan will only pay secondary benefits after 30 months of primary coverage.

Eligibility Audit

Benefit Services may audit a member's documentation to determine whether an enrolled dependent is eligible according to the plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility. Should you have questions after receiving a request to provide proof of dependent eligibility, please contact the Audit Services Unit within the ADOA Benefit Services Division.

Subrogation

Subrogation is the right of an insurer to recover all amounts paid out on your behalf as the insured member. In the event you, as a Benefit Options member, suffer an injury or illness for which another party may be responsible, such as someone injuring you in an accident, and Benefit Options pays benefits as a result of that injury or illness, Benefit Options has the legal right to recover against the party responsible for your illness or injury or from any settlement or court judgment you may receive, up to the amount of benefits paid out by Benefit Options.

As a Benefit Options member, you are required to cooperate with the vendors acting on behalf of ADOA during the subrogation process. Failure to do so may result in legal action by the State to recover funds received by you.

Return to Work Retirees

Former retired State employees returning to active State employment can receive health benefits through the Benefit Options Plan. If a retiree returns to work and meets the eligibility guidelines, they can elect to enroll in Active benefits and decline retiree benefits. Leaving State employment is considered a QLE. The QLE then allows members to enroll in retiree benefits again.

Continuing Eligibility through COBRA

In accordance with the Consolidated Omnibus

Budget Reconciliation Act of 1985 (COBRA), if you experience a loss of coverage due to termination of employment or a qualifying event, you and/or your dependents may extend coverage under the Benefit Options Plan for a limited period of time.

The following individuals would be considered qualified beneficiaries eligible for COBRA coverage:

1. An employee who had coverage through Benefit Options and lost the coverage because of a reduction in hours of employment or a termination of employment for a reason other than gross misconduct.
2. An employee's legal spouse, as defined by Arizona Statute, who had coverage through Benefit Options and lost the coverage for any of the following reasons:
 - Death of the employee;
 - Termination of the employee's employment for a reason other than gross misconduct;
 - Reduction in the employee's hours of employment resulting in a loss of eligibility for coverage;
 - Divorce or legal separation from the employee;
 - The employee becomes eligible for Medicare.
3. An employee's dependent child who had coverage through Benefit Options and lost the coverage for any of the following reasons:
 - Death of the employee (parent);
 - Termination of the parent's employment for a reason other than gross misconduct;
 - A reduction in the parent's hours of employment resulting in a loss of eligibility for coverage;
 - The parents' divorce or legal separation;
 - The parent becomes eligible for Medicare or,
 - The dependent ceases to be a dependent child as defined by the Benefit Options program.

The ADOA Benefit Services Division will determine final eligibility for COBRA coverage. The ADOA Benefit Services Division will determine whether the life event you are experiencing qualifies under the Section 125 regulations. Please see pg. 49 for more information regarding COBRA coverage.

Summary of Monthly Premiums

Medical Without Medicare

	EPO PLAN	PPO PLAN
Retiree Only	\$652.30	\$907.50
Retiree + One	\$1,525.70	\$2,209.90
Family	\$2,055.90	\$2,416.70

Medical with Medicare

	EPO PLAN	PPO PLAN
Retiree Only	\$486.20	\$867.90
Retiree + One (both Medicare)	\$965.80	\$1,733.60
Retiree + One (one Medicare)	\$1,126.40	\$1,914.00
Family	\$1,282.60	\$2,178.00

Dental

	Cigna DHMO	Delta Dental PPO Plus Premier
Retiree Only	\$8.52	\$35.94
Retiree + Adult	\$17.04	\$75.63
Retiree + Child	\$16.59	\$60.48
Retiree + Family	\$25.54	\$118.26

Vision

	Advantage Program	Discount Program ¹
Retiree Only	\$3.99	\$0.00
Retiree + Adult	\$12.94	\$0.00
Retiree + Child	\$12.76	\$0.00
Retiree + Family	\$16.10	\$0.00

1 Members that choose not to enroll in the Advantage Vision Care Program will automatically be enrolled in the Discount Plan at no cost.

Understanding Your Insurance Costs

Calculating your monthly costs, premium benefit, and pension check can be simple. Each retiree's circumstances are different, but understanding how all the pieces work together will make it an easy process. First, premium benefit for the basic program varies depending on your years of service with the State of Arizona, the retirement system you are enrolled in, and the insurance plan in which you enroll. Second, ADOA, ASRS, and PSPRS offer retiree health insurance plans. Premiums differ depending on the plan option selected and whether you are enrolled in single or family coverage.

The worksheet below will help you determine the amount of insurance premiums that will be deducted from your monthly pension. In the event your pension does not cover the net premium, you will be identified as a direct pay member and will be required to pay ADOA or the insurance vendors.

Net Monthly Health Insurance Cost Worksheet		
Your Monthly Medical Plan Premium (<i>see pg. 10</i>)	A	<input type="text"/>
		+
Your Monthly Dental Plan Premium (<i>see pg. 10</i>)	B	<input type="text"/>
		=
Total Premium (A + B = C)	C	<input type="text"/>
		-
Your Basic Premium Benefit Subsidy (<i>see pg. 13</i>)	D	<input type="text"/>
		=
Your Net Premium (C – D = E)	E	<input type="text"/>

What You Should Know About Premium Payments

You are responsible to pay all premiums. Failure to keep your premiums current will result in cancellation of your insurance coverage. If the sum of your premium benefit subsidy and pension is greater than or equal to the total monthly premium, you will be considered a non-direct pay member. Non-direct pay members do not receive a bill.

- If you are an LTD member or Surviving Spouse not receiving a pension from a recognized state retirement plan, you are a direct pay member. You are responsible for the payment of your premium(s) by the first of each month. The monthly premium is stated on your enrollment form.
- If your monthly pension has insufficient funds to cover your health insurance premiums, then premiums will not be deducted. You will then become a direct pay member. The ADOA Benefit Services Division will mail a bill to you. It will be your responsibility to pay any outstanding premiums to Benefit Services. If you do not receive a bill by the twenty-fifth day of the month, you must contact Benefit Services.

- Should the retirement system begin deducting your premium from your pension and you have also received a bill as a direct pay member, please contact Benefit Services. Please see the section entitled, “Information for Direct Pay Members.”

New Retirees/LTD Members

Depending on when the Retirement System receives your benefit elections, you may owe one or more months of health and/or dental premiums. After enrolling, check your pension deductions. If, by your second pension, the deduction has not occurred or the deduction is incorrect, immediately contact ADOA Benefit Services Division, at 602.542.5008.

Information for Direct Pay Members

If you are or become a direct pay member, you will receive a billing notice regarding future premium payments. If you do not receive a billing notice within 60 days, please call ADOA Benefit Services Division at 602.542.5008. Failure to remit premium payments will result in cancellation of your benefits and may affect your eligibility in the Benefit Options program.

Vision Premium Payments

If you elect vision coverage, you will be billed directly from Avesis. Vision premiums are NOT deducted from any pension checks. Avesis will bill you directly.

Your retirement system will determine if you are eligible for a premium benefit and the amount to which you may be entitled. To determine your basic premium benefit:

Calculating your Premium Benefit Subsidy

The Arizona State Retirement System (ASRS), the Public Safety Personnel Retirement System (PSPRS), the Elected Officials Retirement Plan (EORP) and the Corrections Officer Retirement Plan (CORP) may provide payment toward insurance premiums for eligible members and dependents who elect health coverage through ADOA Benefit Services Division. The chart on the next page reflects the maximum monthly premium benefit available for eligible members and their qualified dependents.

No basic premium benefit is provided to Retirees in the University Optional Retirement Plan or to PSPRS or CORP members who are LTD members.

- Your retirement system will determine if you are eligible for a premium benefit and the amount to which you may be entitled. To determine your basic premium benefit, you need to know:
- Your years of credited service in your retirement system or plan if you are an ASRS or EORP member (years of service is not a criterion for CORP and PSPRS members).
- Your coverage type (i.e., single or family coverage).
- Medicare eligibility.

Basic Premium Benefit Subsidy Amounts

	WITHOUT MEDICARE		WITH MEDICARE A & B		COMBINATIONS	
Years of Service	Retiree Only	Retiree & Dependents	Retiree Only	Retiree & Dependents	Retiree & Dependents One with Medicare, the other(s) without	Retiree & Dependent with Medicare, other dependents without
Arizona State Retirement System (ASRS) Members						
5.0–5.9	\$75.00	\$130.00	\$50.00	\$85.00	\$107.50	\$107.50
6.0–6.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
7.0–7.9	\$105.00	\$182.00	\$70.00	\$119.00	\$150.50	\$150.50
8.0–8.9	\$120.00	\$208.00	\$80.00	\$136.00	\$172.00	\$172.00
9.0–9.9	\$135.00	\$234.00	\$90.00	\$153.00	\$193.50	\$193.50
10.0+	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Elected Officials' Retirement Plan (EORP) Members						
5.0–5.9	\$90.00	\$156.00	\$60.00	\$102.00	\$129.00	\$129.00
6.0–6.9	\$112.50	\$195.00	\$75.00	\$127.50	\$161.25	\$161.25
7.0–7.9	\$135.00	\$234.00	\$90.00	\$153.00	\$193.50	\$193.50
8.0+	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Corrections Officer Retirement Plan (CORP) Members						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00
Public Safety Personnel Retirement System (PSPRS)						
not applicable	\$150.00	\$260.00	\$100.00	\$170.00	\$215.00	\$215.00

Your Direct Deposit Summary

Pension payments are issued by ASRS or PSPRS. Before either of the retirement systems generates your pension, they apply your premium subsidy (refer to the worksheet on pg. 11). Once the premium subsidy is added into your pension, the retirement system pays for your dental premium first. ASRS or PSPRS will apply remaining money to pay for your medical premium.

- If your pension is large enough to cover the cost of both your dental and medical premiums, you will receive any remaining money.
- If your pension is not enough to pay for the full cost of your dental and medical premiums you will become a direct pay member.

Please refer to the “Payments” column of the pension Direct Deposit Summary.

An example of an ASRS Direct Deposit Summary is shown on the next page. Please note, under the Payment Sources column, the inclusion of additional monies reflected in the premium benefit (HI PREM BENEFIT). This amount is the premium benefit to which you may be entitled and it reduces the full monthly medical and/or dental premiums you pay.

Also note, under the deductions column, the full health insurance premium for your medical and/or dental coverage (HLTH INS PREM). Though the total premium for health insurance is shown, you are only paying the net premium after the premium benefit is applied.



Arizona State Retirement System
P.O. Box 33910
Phoenix, AZ 85067-3910

IMPORTANT NOTICE

RETAIN FOR YOUR RECORDS THIS IS NOT A CHECK

Contact Us:
(602) 240-2000 (within metro Phoenix)
(520) 239-3100 (within metro Tucson)
(800) 621-3778 (toll free outside metro Phoenix and Tucson)
www.azasrs.gov

JOHN Q PUBLIC
1234 E FIRST ST
MESA AZ 85205-6601

ACCOUNT ID ASR-PMM
PLAN NAME ASRS ANNUITY - PLAN MEMBER

CRP15 AQ001 MNT

DIRECT DEPOSIT SUMMARY

PAYMENT DATE	SOCIAL SECURITY NUMBER	NET PAYMENT
OCTOBER 01, 2010	000-00-0000	2,259.76

PAYMENT DETAIL

PAYMENT SOURCES	CURRENT	YEAR-TO-DATE	DEDUCTIONS	CURRENT	YEAR-TO-DATE
ANNUITY	2,078.42	20,784.20	FEDERAL TAX	606.00	6,050.00
PBI/EPBI	921.12	9,211.20	STTAX-AZ	153.00	1,498.00
NONTAX EXCLU	113.83	1,138.30	HLTH INS PREM	194.61	1,946.10
HI PREM BENEFIT	100.00	1,000.00			
GROSS PAYMENT	3,213.37	32,133.70	TOTAL DEDUCTIONS	953.61	9,494.10

HI PREM BENEFIT: Premium Benefit provided to you which is applied to the cost of the monthly health insurance premium for your medical and dental plan coverage.

HLTH INS PREM: Total Health Insurance Premium for the medical and dental plans in which you are enrolled before **HI PREM BENEFIT** is applied.

YOUR PAYMENT HAS BEEN ELECTRONICALLY TRANSMITTED:

Deposit Account Bank TR#
000000000000000000 000000000000

09

W/H ELECTIONS: FED CALCULATED - S/O+250.00
STATE FLAT PERCENTAGE - 5%

NON - NEGOTIABLE

Parts of Medicare

Parts A & B

To help you calculate your monthly benefit cost, use the worksheet on pg. 11. If you feel your pension is not accurate, you must notify your Retirement System (ASRS or PSPRS) as soon as possible. If your enrollment is not processed until after the third of the month, it is possible the correct premiums will not be deducted from your pension until the month following the effective date of your enrollment or change.

Eligibility

Medicare is health insurance available to people who are:

- Age 65 or over.
- Under age 65 with disabilities (receiving LTD from a State-sponsored LTD plan or SSI).
- Diagnosed with End-Stage Renal Disease.

Medicare eligibility is determined by the Social Security Administration. Many people automatically receive Part A and Part B. If you receive benefits from Social Security, you will receive Part A and Part B starting the first day of the month you turn 65. If you are under the age of 65 and disabled, you automatically receive Parts A and B after you receive disability benefits from Social Security. You should receive your Medicare card in the mail three months before your 65th birthday or your 25th month of disability.

Eligibility Notification

If you become eligible to receive Medicare due to a disability, receive your Medicare Card prior to your 65th birthday, or there is a change in your Medicare status, you must contact the ADOA Benefit Services Division with this information.

When you receive your new Medicare card, you must provide a copy of it to Benefit Services. Medicare does not communicate directly with Benefit Services.

Parts of Medicare

The different parts of Medicare help you cover specific health services. Medicare has the following parts:

Medicare Part A (Hospital Insurance)

- Helps cover inpatient care in hospitals
- Helps cover skilled nursing facility, hospice, and home healthcare

Medicare Part B (Medical Insurance)

- Helps cover doctors' services and outpatient care
- Helps cover some preventive services to help maintain your health

Medicare Part C (Medicare Advantage Plans)

- A health coverage choice run by private companies approved by Medicare
- Includes Part A, Part B, and usually other coverage including prescription drugs

Medicare Part D (Prescription Drug Coverage)

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and help protect against higher costs in the future

If you choose a doctor that does not accept assignment from Medicare, your doctor may be allowed to bill you for additional costs up to the Medicare limiting charge.

If you enroll in either Medicare Part C or Part D plans other than Medicare GenerationRx, you will not be eligible for Benefit Options Medical Coverage. (Example: if you enroll in the Humana Part D Plan outside of the Benefit Options program, you are not eligible to enroll in any of the ADOA Medical Plans.)

Medicare Payments

You will not typically have a monthly premium for Part A if you or your spouse paid Medicare taxes while working. You must pay the standard Medicare Part B premium.

Benefit Options does not pay for Medicare Part B premiums. If you decline or disenroll from Medicare Part B, you will be financially responsible for ALL Part B premiums.

Medicare and ADOA

If you have Medicare Parts A & B during open enrollment, you may elect either the EPO or PPO plan offered at the “with Medicare” premium.

Medicare Primary

If you are retired and receiving a pension from a recognized State-sponsored Retirement Plan, OR you are receiving LTD benefits from a State-sponsored disability plan (Broadspire, Sedgwick, The Standard, Cigna, or The Hartford):

- Medicare is primary coverage
- Benefit Options is secondary coverage

How it Works

Medicare Parts A and B will only pay 80% of covered charges once you have met your deductible. Doctors often charge patients the remaining portion of the bill that Medicare has not paid. If you enroll in the Benefit Options plan the remaining portion less copays (20%) will be covered since Benefit Options becomes the secondary payor. Benefit Options will pay up to the total allowable amount less copays as determined by the Plan.

If you are enrolled in Medicare Part A only, you are still Medicare-eligible. If you decline Part B, you will be responsible for Part B covered charges.

Copays

A copay is a portion paid by the member to share in the cost of medical services, supplies and prescriptions. Cost sharing helps Benefit Options with healthcare costs. Medicare also applies cost sharing. For covered services, the Benefit Options plans absorb the Medicare deductible you would otherwise pay for hospital and medical services. The Benefit Options program will pay up to the total allowable amount as determined by the Plan. Most physicians charge 20% above the amount covered by Medicare. Copays are required for all plan members regardless of Medicare eligibility or disability. Your medical provider understands medical payments will be reduced by the copay. Therefore, the copay must be made at the time the services are rendered.

Medicare Crossover Program

Medicare Crossover is a process by which Medicare automatically forwards medical claims to your health plan after they have paid as the primary payor. All medical vendors have a Medicare Crossover program. Please call the number on the back of your card and let them know you would like to enroll in the Medicare Crossover program.

Medicare Part D

The Medicare Modernization Act (MMA) established a voluntary prescription drug benefit known as Medicare Part D. This benefit is offered to all Medicare-eligible Retirees or LTD members enrolled in Medicare Parts A and/or B.

All ADOA's Medicare Prescription Drug Plan (PDP) Plan Medicare-eligible participants covered under the State of Arizona Benefit Options Program must enroll in Medicare PDP that combines a standard Medicare Part D plan with additional prescription drug coverage provided by Benefit Options. The plan name is Medicare GenerationRx (Employer PDP). We refer to this program as Medicare GenerationRx for Benefit Options.

Low Income Subsidy (LIS)

Medicare-eligible retirees and their Medicare-eligible dependents with limited income may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare may pay for up to 100% of drug costs, and coinsurance/copayments.

Eligible members are identified during the enrollment process. Plan participants that are eligible will receive a Low-Income Subsidy (LIS) Rider with their Explanation of Coverage explaining their benefit.

For more information about Extra Help, members may contact their local Social Security office or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1.877.486.2048, or visit [medicare.gov](https://www.medicare.gov).

Part D Income Related Monthly Adjustment Amount (IRMAA)

If a member's income is greater than \$85,001 for an individual (or married individuals filing separately) or greater than \$170,001 for married couples Medicare requires that you pay an additional premium based on your income. You will be notified by Social Security if this affects you.

For more information about Part D premiums based on income, visit [medicare.gov](https://www.medicare.gov) on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1.877.486.2048. Members may also call Social Security at 1.800.772.1213. TTY/TDD users should call 1.800.325.0778.

The Medicare GenerationRx for Benefit Options plan provides equal to or better coverage than what is offered through Medicare Part D. Learn more about Medicare GenerationRx for Benefit Options on pg. 34.

Medical Plan Information

Understanding Your Options

Retirees have the option of two statewide and nationwide plans, four Networks, and four coverage tiers. “Network”, describes the company contracted with the State to provide access to a group of providers (doctors, hospitals, etc.). Certain providers may belong to one Network but not another. Plans are loosely defined as the structure of your insurance policy: the premium, deductibles, copays, and out-of-Network coverage. A tier describes the number of persons covered by the medical plan.

How the Plans Work

There are two medical plans offered under Benefit Options. They are the Exclusive Provider Organization (EPO), and the Preferred Provider Organization (PPO).

The EPO Plan

If you choose the EPO plan under Benefit Options you must obtain services from a Network provider. Out-of-Network services are only covered in emergency situations. Under the EPO plan, you will pay the monthly premium and any required copay at the time of service. The EPO plan is available with all four Networks: Aetna, Blue Cross Blue Shield of Arizona, Cigna, and UnitedHealthcare. Choose the Network based on the physicians. The benefit is the same.

The PPO Plan

If you choose the PPO plan under Benefit Options you can see providers in-Network or out-of-Network, but will have higher costs for out-of-Network services. Additionally, there are in-Network and out-of-Network deductibles that must be met before the copay or coinsurance applies. Under the PPO plan, you will pay the monthly premium and the plan deductible or any required copay or coinsurance (percent of the cost) at the time of service. The PPO plan is available with Aetna, Blue Cross Blue Shield of Arizona, and UnitedHealthcare. Choose the Network based on the physicians. The benefit is the same.

Choosing the Best Plan for Your Needs

The first thing to know when making your medical benefit elections with Benefit Options is that the coverage is the same for all choices. This means that the same services are covered under the EPO and PPO, but the network of providers is different. To choose the right plan for you:

1. Assess the costs you expect in the coming year including: premiums, copays, and coinsurance. Refer to pg. 20 for plan comparisons to help determine costs.
2. Determine if your doctors are contracted with the Network you are considering. Each medical Network has a website or phone number to help you determine if your doctor is contracted with the Network.
3. Once you have selected which plan best suits your needs and your budget, make your benefit elections online.

Transition of Care (TOC)

If you are undergoing an active course of treatment with a doctor who is not contracted with one of the Networks, you can apply for transition of care. TOC forms are available on the Benefit Options website benefitoptions.az.gov.

If you are approved, you will receive in-Network benefits for your current doctor during a transitional period after January 1, 2018. Transition of care is typically approved if one of the following applies:

1. You have a life-threatening disease or condition;
2. You have been receiving care and a continued course of treatment is medically necessary;
3. You are in the third trimester of pregnancy; or
4. You are in the second trimester of pregnancy and your doctor agrees to accept our reimbursement rate and to abide by the Plan's policies, procedures, and quality assurance requirements.

ID Cards

ID cards are provided only to members who are newly enrolled or make a change to their benefit plan. Personal insurance cards arrive 7-14 business days after the benefit becomes effective.

A new card or replacement ID card can be obtained by contacting the appropriate vendor to request a card, print card via the vendor website, or by downloading the vendor app on your mobile device.

Medical Plan Comparison Charts

		EPO PLAN ¹	PPO PLAN	
		IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
		Aetna BCBSAZ Cigna UnitedHealthcare	Aetna BCBSAZ ² UnitedHealthcare	
Plan Year Deductible³	EE Only	None	\$500	\$1,000
	EE + Adult	None	\$1,000	\$2,000
	EE + Child	None	\$1,000	\$2,000
	Family	None	\$1,000	\$2,000
Out-of-Pocket Maximum^{3,4}	EE Only	\$7,350	\$1,000	\$4,000
	EE + Adult	\$14,700	\$2,000	\$8,000
	EE + Child	\$14,700	\$2,000	\$8,000
	Family	\$14,700	\$2,000	\$8,000
Lifetime Maximum		Unlimited	Unlimited	Unlimited
RETIREE COPAYMENT / CO-INSURANCE²				
Behavioral Health	Inpatient	\$250	\$250	50% after deductible
	Outpatient	\$20	\$20	50% after deductible
Chiropractic		\$40	\$40	50% after deductible
Durable Medical Equipment		\$0	\$0	50% after deductible
Emergency ER copay waived if admitted	Ambulance	\$0	\$0	10% after deductible
	ER	\$200	\$200	\$200
	Urgent care	\$75	\$75	50% after deductible
Inpatient Hospital Admission		\$250	\$250	50% after deductible
Laboratory		\$0	\$0	50% after deductible
Office Visits	PCP	\$20	\$20	50% after deductible
	Preventive	\$0	\$0	50% after deductible
	Specialist ⁵	\$40	\$40	50% after deductible
	OB/GYN	\$20	\$20	50% after deductible
Outpatient Services		\$100	\$100	50% after deductible
Radiology (CAT, MRI, PET) (X-rays are covered 100%⁶)		\$100	\$100	50% after deductible

- 1 If a member goes out-of-Network, there is no coverage, except in emergency situations.
- 2 For the NAU only BCBS PPO Plan details, go to nau.edu/human-resources/benefits/benefit-plan-document/
- 3 Copayments apply after the Plan deductible is met. Copayments and Deductible apply to the out-of-pocket maximum.
- 4 The Plan pays 100% after the out-of-pocket maximum is met.
- 5 All Mayo Clinic Primary Care Physicians (PCP) contract with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the \$40 specialist copayment.
- 6 EPO/PPO plans only.

Network Options Outside Arizona

The chart below indicates the coverage options and Networks for members who live out-of-state. All four medical Networks offer statewide and nationwide coverage and are not restricted to regional areas. All plans are available in all domestic locations. However, not all plans have equal provider availability, so it is important to check with your current provider to determine if he/she is contracted with your selected Medical Network.

	EPO NETWORK	PPO NETWORK	HDHP with HSA NETWORK
Aetna	Aetna Select Open Access	Aetna Choice POS II Open Access	Aetna Choice POS II Open Access
BCBSAZ	BlueCard	BlueCard	Not Available
Cigna	Cigna Open Access Plus	Not Available	Not Available
UHC	UHC Choice	UHC Options PPO	Not Available

Medical Website Features

You can review your personal profile, view the status of medical claims, obtain general medical information, and learn how to manage your own healthcare through the available health plan websites.

Aetna

Non-member: aetnastateaz.com

Existing member: aetna.com



DocFind

Use this online directory to find out if your physician or hospital is contracted with Aetna.

Aetna members can create a user name and password and have access to:

Aetna Navigator—Review Your Plan and Benefits Information

You can verify your benefits and eligibility. You will also have access to detailed claims status and claim Explanation of Benefits (EOB) statements.

ID Card

Print a temporary or order a replacement ID card.

Contact and E-mail

Access contact information for Aetna Member Services as well as Aetna's 24/7/365-day NurseLine. Chat live with member service representatives for quick, easy and secure assistance by using the Live Help feature within the Aetna portal.

Health Information—Simple Steps to Healthier Life

This website will give you access to wellness information.

Estimate the Cost of Care

You can estimate the average cost of healthcare services in your area including medical procedures and medical tests.

Personal Health Record

Access and print historical claims information that may be useful to you and your healthcare professional.

Aetna Mobile

Simply type aetna.com in your smart phone to access doctors, Aetna Navigator, and much more. There is an iPhone or Android application available for downloading.

Blue Cross Blue Shield of Arizona
Non-member: adoa.azblue.com
Existing member: azblue.com



Lookup Provider

Use this tool to find out if your doctor, hospital, retail clinic, or urgent care provider is contracted with Blue Cross Blue Shield of Arizona.

Blue Cross Blue Shield of Arizona members can create a user ID and password to have access to:

ID Card

Order a new ID card or print a temporary one.

Care Comparison

This simple online tool gives you access to price ranges for many common health care services right down to the procedure and the facility in your area. You can also view cost information across many specialties including radiology, orthopedics, obstetrics, and general surgery.

Hospital Compare

In this tool, you will find information on how well hospitals care for patients with certain medical conditions or surgical procedures, and results from a survey of patients about the quality of care they received during a recent hospital stay.

Claims Inquiry

View and read the detailed status of all medical claims submitted for payment. You can also obtain your Explanation of Benefits (EOB) or Member Health Statement.

Optional Electronic Paperless EOB

Reduce mail, eliminate filing and help the planet by going green.

Coverage Inquiry

Verify eligibility for you and your dependents.

Wellness Tools

You can access wellness information through your personal HealthyBlue homepage.

Online Forms

You can find important forms and information online, including a medical claim form and medical coverage guidelines.

Help

You can find information on how to contact Blue Cross Blue Shield of Arizona regarding your benefits, claims, or any other questions you may have.

Cigna

Non-member: Cigna.com/stateofaz

Existing member: myCigna.com



For retirees not enrolled in the Cigna plan, visit Cigna.com/stateofaz for a provider listing, program and resource information.

For retirees already enrolled in the Cigna plan, please visit myCigna.com, for access to:

Personal Profile

You can verify your coverage, copays, deductibles, and view the status of claims.

ID Card

Order a new ID card or print a temporary one.

Evaluate Costs

You can find estimated costs for common medical conditions and services.

Rank Hospitals

Learn how hospitals rank by cost, number of procedures performed, average length of stay, and more.

Assess Treatments

You can get facts to make informed decisions about condition-specific procedures and treatments.

Conduct Research

With an interactive library, you can gather information on health conditions, first aid, medical exams, wellness, and more.

Health Coaching

Take a quick health assessment, get personalized recommendations and connect to immediate online coaching resources.

Monitor Health Records

Keep track of medical conditions, allergies, surgeries, immunizations, and emergency contacts. You can download a free, personalized smart phone app. From there, you can do almost anything on the go – from getting your ID cards, account balances, locating doctors and hospitals, and so much more. Get the myCigna Mobile app today!

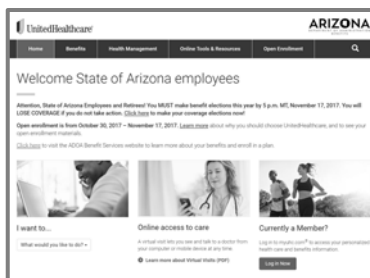
Note: All Mayo Clinic Primary Care Physicians (PCP) are contracted with Cigna HealthCare as specialists, therefore all primary care services administered by Mayo PCPs will be subject to the \$30 specialist copayment. If you choose a doctor that does not accept assignment from Medicare, your doctor may be allowed to bill you for additional costs up to the Medicare limiting charge.

UnitedHealthcare

Non-member:

welcometouhc.com/stateofaz

Existing member: myuhc.com®



Visit your support site: welcometouhc.com/stateofaz

From this site, you can access benefit information, learn about available tools, resources and programs, view open enrollment materials and more.

- View and compare benefit plan options
- Learn more about wellness programs, specialized benefits and online tools
- Search for physicians, facilities, and access our site for members, myuhc.com.

Need a new doctor or a specialist?

You can search for doctors near you and even see which doctors have been recognized by the UnitedHealth Premium® program for quality and cost-efficiency.

Your health, your questions, your myuhc.com

Once you become a member, your first stop is your member website, myuhc.com. It's loaded with details on your benefit plan and much more.

ID Card

Order a new ID card or print a temporary one.

Want to get rid of that nagging pain, but worried about the cost?

You can see what a treatment or procedure typically costs and see what your share of expenses may be.

Looking for an easier way to manage claims?

You can track claims, mark claims you've already paid, and review graphs to better understand what you owe. You can even make claim payments online.

Stay healthy with innovative health and wellness tools.

- Wellness tools and health checklists give you tips on living healthy and using health plan benefits to your advantage.
- Get reminders when it's time for checkups. Plus, get suggestions for other covered services, like immunizations, well-visits, routine tests, or lab work.
- Pursue your health goals. Through exciting interactive tools, you can participate in missions and have fun while focusing on wellness.
- Sync your wearable devices- like Fitbit® or Apple Watch® –for accurate reporting and results. You can even earn coins to enter for a chance to win a prize!

Always on the go? We can help you there too.

Whether you need to find urgent care, you forget your health plan ID card, or need to call customer service, the UnitedHealthcare Health4Me™ mobile app helps put your insurance information in the palm of your hand.

Medical Management

Services Available

When you choose Benefit Options medical insurance you get more than basic healthcare coverage. You get personalized medical management programs at no additional cost. Under the Benefit Options health plan, the medical Network you select during open enrollment serves their specific members.

Professional, experienced staff work on your behalf to make sure you are getting the best possible care and that you are properly educated on all aspects of your treatment.

Utilization Management

Each Medical network provides prior authorization and utilization review for the ADOA Benefit Options plans when members require non-primary care services. Prior to any elective hospitalization and/or certain outpatient procedures, you or your doctor must contact your medical Network for authorization. Please refer to your Plan Document for the specific list of services that require prior authorization. Each Network has a dedicated line to accept calls and inquiries:

- Aetna 1.800.333.4432
- Blue Cross Blue Shield of Arizona 1.800.232.2345 ext. 4320
- Cigna 1.800.968.7366
- UnitedHealthcare 1.800.896.1067

Case Management

Case management is a collaborative process whereby a case manager from your selected medical Network works with you to assess, plan, implement, coordinate, monitor, and evaluate the services you may need.

Often case management is used with complex treatments for severe health conditions. The case manager uses available resources to achieve cost effective health outcomes for both the member and the State of Arizona.

Disease Management

The purpose of disease management programs is to educate you and/or your dependents about complex or chronic health conditions. The programs are typically designed to improve self-management skills and help make lifestyle changes that promote healthy living.

The following disease management programs are available to all Benefit Options members regardless of their selected Networks:

- Asthma
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Pregnancy/Maternity
- Coronary Artery Disease
- Healthy Back

If you are eligible or become eligible for one of the programs above, a disease manager from your selected Network will assess your needs and work with your physicians to develop a personalized plan. Your personalized plan will establish goals and steps to help you to positively change your specific lifestyle habits and improve your health.

Your assigned disease manager may also:

- Provide tips on how to keep your diet and exercise program on track
- Help you to maintain your necessary medical tests and annual exams
- Offer tips on how to manage and control stress along with the associated symptoms.
- Assist with understanding your doctor's treatment plan
- Review and discuss medications, how they work and how to use them

Generally, a disease manager will work with you as quickly or as slowly as you like - allowing you to complete the program at your own pace. Over the course of the program, participants learn to incorporate healthy habits and improve their overall health.

Getting Involved

The Benefit Options disease management programs offered through each medical Network identify and reach out through phone calls and/or mail to members who may need help managing their health conditions.

The medical Networks work with the Benefit Options plan to provide this additional service. Participation is optional, private, and tailored to your specific needs. Also, members of the Benefit Options plan who are concerned about a health condition and would like to enroll in one of the covered programs can contact their respective medical Networks directly to self-enroll.

Please refer to your medical Network's phone number on pg. 60 if you or your dependent is interested.

NurseLine

A dedicated team of nurses, physicians, and/or dietitians are available 24/7 for member consultations. Members needing medical advice or who have treatment questions can call the toll-free NurseLine:

Aetna 1.800.556.1555

Blue Cross Blue Shield of Arizona 1.866.422.2729, Option 9

Cigna 1.800.968.7366

UnitedHealthcare 1.800.401.7396

Pre-Medicare Pharmacy Plan Information

MedImpact

If you elect any Benefit Options medical plan, MedImpact will be the Network you use for pharmacy benefits. Enrollment is automatic when you enroll in the medical plan.

MedImpact currently services 50 million members nationwide, providing leading prescription drug clinical services, benefit design, and claims processing since 1989 through a comprehensive Network of pharmacies.

ID Card

You will not receive a pharmacy ID card. The MedImpact Customer Care information can be found on the back of the ID card provided by your medical network.

How it Works

All prescriptions must be filled at a Network pharmacy by presenting your medical card. You can also fill your prescription through the mail order service. The cost of prescriptions filled out-of-Network will not be reimbursed.

No international pharmacy services are covered. Be sure to order your prescriptions prior to your trip and take your prescriptions with you.

The MedImpact plan has a three-tier formulary described in the chart on pg. 31. The copays listed in the chart are for a 31-day supply of medication bought at a retail pharmacy.

Formulary

The formulary is the list of medications chosen by a committee of doctors and pharmacists to help you maximize the value of your prescription benefit. These generic and brand name medications are available at a lower cost. The use of non-preferred medications will result in a higher copay. Changes to the formulary can occur during the plan year. Medications that no longer offer the best therapeutic value for the plan are deleted from the formulary. Ask your pharmacist to verify the current copay amount at the time your prescription is filled.

To see what medications are on the formulary, go to benefitoptions.az.gov or contact the MedImpact Customer Care Center and ask to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.

Finding a Pharmacy

To find a pharmacy refer to benefitoptions.az.gov. See online features for more information.

The MedImpact Customer Care Center is available 24 hours a day, 7 days a week. The toll-free telephone number is 1.888.648.6769.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for retirees who require medications for on-going health conditions or who will be in an area with no participating retail pharmacies for an extended period.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician.
- Request up to a 90-day supply of medication for two copays
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at walgreens.com or via phone at 1.866.304.2846. Have your insurance card ready when you call.

Choice90

With this program, members who require medications for an on-going health condition can obtain a 90-day supply of medication at a local retail pharmacy for two and a half copays. For more information, contact MedImpact Customer Care Center at 1.888.648.6769.

Medication Prior Authorization

Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. These prescriptions may be limited to quantity, frequency, dosage or may have age restrictions. The authorization process may be initiated by you, your local pharmacy, or your physician by calling MedImpact at 1.888.648.6769.

Step Therapy Program

Step Therapy is a program which promotes the use of safe, cost-effective and clinically appropriate medications. This program requires that members try a generic alternative medication that is safe and equally effective before a brand name medication is covered. For a complete list of drugs under this program, please refer to the formulary at benefitoptions.az.gov.

Specialty Pharmacy Program

Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Specialty Pharmacy Program. This program assists you with monitoring your medication needs and provides patient education.

Specialty medications are limited to a 31-day supply and may be obtained only at a Walgreens retail pharmacy or through the Walgreens Specialty Central Fill facility by calling 1.888.782.8443.

A Specialty Care Representative may contact you to facilitate your enrollment in the Specialty Pharmacy Program. You may also enroll directly into the program by calling 1.888.782.8443.

Limited Prescription Drug Coverage

Prescription drug coverage will generally be limited to medications that do not have an equally effective over-the-counter substitute.

Non-Covered Drugs

Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

Extended Vacation or Travel Abroad

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify MedImpact in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone. MedImpact will be able to authorize a VACATION OVERRIDE allowing you to have extra medication you will need provided you have the appropriate number of refills remaining.

Order refills at least two weeks in advance of your departure. If there is a problem, such as, not enough refills, you will have enough time to phone your physician. If you're using Mail Order, contact MedImpact at least three weeks in advance.

If you are already out of town and need a prescription call MedImpact. Tell the representative you are out of town and need to find a participating pharmacy in the area where you are. You will need the zip code where you are visiting. In most cases you will have several choices.

If your medication is lost, stolen, or damaged, replacement medication is not covered.

Contacts

<i>MedImpact</i>	
Customer Care Center and Prior Authorization	1.888.648.6769
MedImpact BIN Number	003585
Retail PCN Number	28914

<i>Walgreens</i>	
Mail Order	1.866.304.2846
Specialty Pharmacy	1.888.782.8443

Pre-Medicare Pharmacy Co-Pays

ADOA Benefit Options (Aetna, Blue Cross Blue Shield of Arizona, Cigna, UnitedHealthcare)	
Pharmacy Benefits Administered By	MedImpact
Retail Requirements	In-Network pharmacies only, one copay per prescription
Mail Order	Two copays for 90-day supply
Choice90	Two & 1/2 copays for 90-day supply
Generic	\$15 copay
Preferred Brand¹	\$40 copay
Non-Preferred Brand¹	\$60 copay
Annual Maximum	See Summary Plan Description
<i>1 Member may have to pay more if a brand is chosen over a generic. Note: Copays for compounded medications are based on the formulary placement of the main compound ingredient.</i>	

NAU Retiree BCBS Members only

There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic, preferred brand, non-preferred brand A, or non-preferred brand B copay.

The BCBSAZ Prescription Medication Guide can be used to determine your copay and this guide can be found on the BCBS website at bcbsaz.com. Go to four level prescription drug benefits.

Up to a 90-day supply of maintenance drugs (the same drug and drug strength) may be obtained through the Walgreens Prescription Drug Mail-Order Program. Maintenance drugs are drugs you take consistently. The copay for the 90-day supply is equivalent to one month's copay for Level 1 and 2 Prescriptions and equal to two co-pays for Level 3 and Level 4 prescriptions.

Pre-Medicare Pharmacy Website Features

Members can view pharmacy information located at **benefitoptions.az.gov**. Click on the pharmacy link and then click “MedImpact Pharmacy Website”.

Members can create a user name and password to have access to:

- ☐ **Benefit Highlights**
View your current copay amounts and other pharmacy benefit considerations.
- ☐ **Formulary Lookup**
Research medications to learn whether they are generic, preferred or nonpreferred drugs. This classification will determine what copay is required. You can search by drug name or general therapeutic category.
- ☐ **Prescription History**
View your prescription history, including all the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.
- ☐ **Drug Search**
Research information on prescribed drugs like how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
- ☐ **Health & Wellness**
Learn valuable tips and information on diseases and health conditions.
- ☐ **Mail Order**
A link will direct you to the Walgreens website where you may register for mail order service by downloading the registration form and following the step-by-step instructions.
- ☐ **Locate a Nearby Pharmacy**
Locate a pharmacy near your home address, out-of-town vacation address, or your dependent’s address.
- ☐ **Generic Resource Center**
Learn more about generic drugs and savings opportunities.
- ☐ **Choice90**
Learn more about the Choice90 option. With this program, you can obtain a 90-day supply of medication for a reduced copay.
- ☐ **NAU Retirees**
Blue Cross Blue Shield Members Only
Refer to more information by accessing Blue Net, Blue Cross Blue Shield of Arizona’s online member website at bcbsaz.com. Information on the pharmacy plan and copay levels for prescriptions can be found at bcbsaz.com. Go to 4-level prescription drug benefit.

Medicare Pharmacy Plan Information

Medicare GenerationRx (Employer PDP)

For Medicare eligible retirees & Medicare eligible dependents. If you elect any Benefit Options medical plan, you will be automatically enrolled in Medicare GenerationRx for Benefit Options.

Enrollment in this plan depends on contract renewal. All Medicare GenerationRx communications will include the Medicare GenerationRx logo.



How it Works

Medicare-eligible retirees and their Medicare-eligible dependents enrolled in Medicare GenerationRx will each receive their own prescription drug ID card.

The new ID card will be issued by Medicare GenerationRx, and will NOT replace your medical card. The new prescription drug ID card is in addition to your medical card. Show your Medicare GenerationRx card when you fill your prescription medications at the pharmacy.

Members will need to use their new Medicare GenerationRx prescription ID card if they're enrolled in Medicare GenerationRx Part D Prescription Drug Program for Benefit Options. Members will receive their new card within 10 days of their effective date.

All prescriptions must be filled at a Network pharmacy by presenting your Medicare GenerationRx prescription ID card. You can also fill your prescription through the Walgreens mail order service.

The Medicare GenerationRx for Benefit Options plan has a four-tier formulary.

The Plan provides you full coverage so there is no Coverage Gap, or "Donut Hole." This allows your cost sharing to remain consistent. You pay the same copays throughout the year during all the Medicare Part D stages.

If you reach the catastrophic coverage stage (\$5,000 in total out-of-pocket costs for 2018), your Benefit Options copayment will be the maximum amount charged.

Benefits, formulary pharmacy network, premium and/or co-payments/co-insurance may change on January 1 of each year.

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply. For more information contact Medicare GenerationRx.

Formulary

The formulary is the list of medications chosen by a committee of doctors and pharmacists to help maximize the value of your prescription benefit.

Members will use Medicare GenerationRx's four-tier formulary. Generic and brand name medications are available at a lower cost.

Generally, your formulary will not change during the year except for cases in which you can save additional money or to ensure your safety. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective.

Medicare Prescription Drug Plan Copays			
Tier Number / Name	Retail (up to 31-day supply)	Mail Order (up to 90-day supply)	Choice90Rx Extended supply at retail (up to 90-day supply)
Tier 1: Generic	\$15	\$30	\$37.50
Tier 2: Preferred Brand	\$40	\$80	\$100
Tier 3: Non-Preferred Brand	\$60	\$120	\$150
Tier 4: Specialty - Over \$670¹	\$60	Not available	Not available
<i>1 Total medication cost.</i>			

Some drugs may have additional requirements or limits on coverage. These requirements and limits may include:

Prior Authorization

Prescriptions for certain medications may require clinical approval before they can be filled, even with a valid prescription. You or your physician will need to obtain approval from Medicare GenerationRx before these drugs can be covered by the plan.

Step Therapy Program

The program promotes the use of safe, cost-effective and clinically appropriate medications. This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "step therapy".

Quantity Limits

For certain drugs, Medicare GenerationRx limits the amount of the drug that Medicare GenerationRx will cover. To see what medications are on the formulary and get additional information about drug restrictions, go to medicaregenerationrx.com/stateofaz or call Medicare GenerationRx's Member Services at 1.877.633.7943. TTY users should call 711. Member Services is available 24 hours a day, 365 days a year. Sharing this information with your doctor helps ensure you are getting the best value, which saves money for you and your plan.

The formulary may change at any time. You will receive notice when necessary.

Finding a Pharmacy

Medicare GenerationRx has over 65,000 pharmacies in its network. Members may continue to fill their prescriptions at their current pharmacy if it is a MedicareGenerationRx for Benefit Options network pharmacy.

Members may request a pharmacy directory from Member Services or use the online Pharmacy Locator at medicaregenerationrx.com/stateofaz.

The pharmacy network may change at any time. You will receive notice when necessary.

Pharmacy Mail Order Service

A convenient and less expensive mail order service is available for members who need medications for ongoing health conditions or who will be in an area with no participating retail pharmacies for an extended period.

Here are a few guidelines for using the mail order service:

- Submit a 90-day written prescription from your physician, but verification is required every 30 days.
- Auto refill is not available.
- Request up to a 90-day supply of medication for two copays. (Example: A 31-day supply retail prescription for a \$10 copay versus a 90-day supply mail order prescription for a \$20 copay)
- Payments can be made by check or credit card: Visa, MasterCard, American Express, or Discover.
- Register your e-mail address to receive information on your orders.
- Order refills online at Walgreens.com or via phone at 1.866.304.2846. Have your prescription card ready when you call!

Choice90Rx

With this program, members who require medications for an ongoing health condition can obtain a 90-day supply of medication at a local retail pharmacy for two and a half copays.

For more information or to find a participating Choice90Rx pharmacy, please visit our web site at medicaregenerationrx.com/stateofaz, refer to your Pharmacy Directory or call Medicare GenerationRx Member Services at 1.877.633.7943, 24 hours a day/365 days a year. TTY/TDD users should call 711.

Specialty Pharmacy Program

If you are taking a medication that is on the Specialty tier of your prescription benefit, you may use Walgreens Specialty pharmacy, or any specialty pharmacy in the Medicare GenerationRx specialty pharmacy network.*

*Other pharmacies are available in our network. To enroll in Walgreens Specialty Pharmacy's Patient Care Programs, please call 1.888.782.8443 to speak with a Patient Care Coordinator. Walgreens Specialty Pharmacy will reach out to your health care provider to get a new prescription for you or have your specialty prescriptions transferred from your current pharmacy. For more information on Walgreens Specialty Pharmacy, visit walgreens.com/specialty.

Specialty medications are limited to a 31-day supply.

Under Medicare Part D

Extra Help (Low Income Subsidy)

Eligible retirees and their dependents with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If eligible, Medicare could pay for up to 100% of drug costs including coinsurance/copayments.

Additionally, those who qualify will not be subject to the coverage gap or a late enrollment penalty. Many Medicare eligible retirees and their dependents are eligible for these savings and don't even know it.

Members eligible for “Extra Help” are identified during the enrollment process. Plan participants that are eligible will receive a Low-Income Subsidy (LIS) Rider with their Explanation of Coverage explaining what their benefit will be.

For more information about Extra Help, members may contact their local Social Security office or call 1.800.MEDICARE (1.800.633.4227), 24 hours per day, 7 days a week. TTY/TDD users should call 1.877.486.2048, or visit [medicare.gov](https://www.medicare.gov).

Part D Income Related Monthly Adjustment Amount (IRMAA)

Some Medicare eligible members and their dependents pay an extra amount for Part D because of their yearly income. If a member’s modified adjusted gross income is \$85,001 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, they must pay an extra amount directly to the government (not the Medicare plan) for Medicare Part D coverage.

- If a member is required to pay the extra amount and does not pay it, they will be disenrolled from the plan and lose prescription drug coverage.
- If the member needs to pay an extra amount, Social Security, not the Medicare plan, will send the member a letter telling them what that extra amount will be.
- For more information about Part D premiums based on income, visit [medicare.gov](https://www.medicare.gov) on the web or call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Members may also call Social Security at 1.800.772.1213. TTY users should call 1.800.325.0778.

The booklet Medicare & You 2018 gives information about the Medicare premiums in the section called “2018 Medicare Costs.” This explains how the Medicare Part B and Part D premiums differ for Medicare eligible members and their dependents with different incomes.

Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2018 from the Medicare website ([medicare.gov](https://www.medicare.gov)). Or, you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

Many members are required to pay other Medicare premiums. Some plan members (those who aren’t eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members also pay a premium for Medicare Part B.

Members who owe the income-related monthly adjustment amount (IRMAA or “extra amount”) will receive a letter directly from the Social Security Administration (SSA). Medicare GenerationRx is not aware whether the member qualifies for this additional premium or not as it is managed strictly through the SSA.

Medicare GenerationRx is only made aware of IRMAA if the member is disenrolled for non-payment. See Ch. 4, Section 11 of the Evidence of Coverage for more information about the extra amount.

If a member feels they should not have to pay the additional premium, they should call the SSA number listed in the letter.

SSA will either make an appointment for the member at their local SSA office or they will transfer them to the local SSA phone number for an income re-determination. A member’s income may have increased/decreased due to capital gains (e.g. sale of a home, cashing in a 401k, marriage, divorce or death).

Extended Vacation or Travel Abroad

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need.

Whether you go to a retail pharmacy or use mail order for your prescriptions, you will need to notify Medicare GenerationRx in writing of why you are requesting an additional supply of medication, the date when you are leaving, and how long you plan to be gone.

Medicare GenerationRx will generally be able to authorize a VACATION OVERRIDE allowing you to have the extra medication you will need provided you have the appropriate number of refills remaining. Order refills at least two weeks in advance of your departure. If there is a problem, such as, not enough refills, you will have enough time to phone your physician. Copays will be the same as you would normally pay times the number of refills you need.

Medicare GenerationRx cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Contact Information

Medicare GenerationRx Member Services is available to address pharmacy plan questions. Representatives are available 24 hours a day, 365 days a year at 1.877.633.7943. TTY users should call 711. Language translation services are available.

Pharmacies and providers may call the Medicare GenerationRx Pharmacy and Provider Help Desk at 1.888.678.7789. Representatives are available 24 hours a day, 365 days a year. TTY users should call 711.

To view your Medicare GenerationRx for Benefit Options plan benefits find a participating pharmacy or look up the price of your drugs, visit medicaregenerationrx.com/stateofaz.

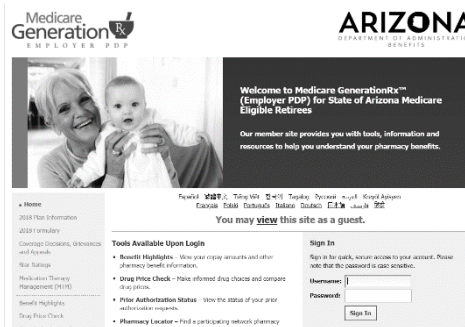
iRx Discount Program

You may be able to obtain a discount on certain brand and generic medications that are not covered by your ADOA pharmacy drug plan, through the iRx Program™. Present your Medicare GenerationRx ID card at any participating pharmacy, along with your prescription for the medication. Savings are applied automatically when the item prescribed qualifies for a discount. The amount of the discount will vary based on pharmacy chosen and type of medication.

Medicare has neither reviewed nor endorsed this information.

Medicare Pharmacy Website Features

Members can view pharmacy information at medicaregenerationrx.com/stateofaz



Members can create a user name and password to have access to:

- ☐ **Benefit Highlights**
View your current copay amounts and other pharmacy benefit considerations.
- ☐ **Prescription History**
View your prescription history, including all the medications received by each member, under PersonalHealth Rx. Your prescription history can be printed for annual tax purposes.
- ☐ **Drug Price Check**
Review prescription choices and compare drug prices. Search by drug name to view formulary status, tier and your cost.
- ☐ **Mail Order**
A link will direct you to the Walgreens website where you may register for mail order service by downloading the registration form and following the step-by-step instructions. Auto refill is not available.
- ☐ **Locate a Nearby Pharmacy**
Locate a pharmacy near your home address, out-of-town vacation address, or your dependent's address.
- ☐ **Generic Resource Center**
Learn more about generic drugs and savings opportunities.

Dental Plan Information

Retirees may choose between two plan types: the Prepaid/DHMO and the Indemnity/Preferred Provider Organization (PPO) plans. Each plan's notable features are bulleted below.

Prepaid/DHMO Plan: Cigna Dental

- You MUST use a Prepaid/DHMO Participating Dental Provider (PDP) to provide and coordinate all of your dental care
- No annual deductible or maximums
- No waiting periods
- Pre-existing conditions are covered
- Specific copays for services
- Specific lab fees for prosthodontic materials

Each family member may choose a different general dentist from the DHMO provider network. You can select or change your dentist by contacting Cigna by telephone. Members may self-refer to dental specialists within the Network. Specialty care copays are listed in the Patient Charge Schedule. Specialty services not listed are provided at a discounted rate. This discount includes services at a Periodontist, Prosthodontist, and TMJ care.

Availability: The Cigna DHMO is not available if you reside in the following states: AK, MI, ME, MT, NH, NM, ND, PR, RI, SD, VT, WV and WY. See availability map on page 41.

Indemnity/PPO Plan: Delta Dental PPO plus Premier

As a State of Arizona eligible member, you can enroll in the Delta Dental of Arizona – PPO plus Premier plan with covered preventive services.

- Your preventive and diagnostic services are covered at 100% and are not subtracted from your annual maximum
- Your annual maximum benefit is \$2,000 per benefit year
- No deductible for diagnostic and routine services
- \$50 deductible per person and no more than \$150 per family
- The maximum lifetime benefit for orthodontia is \$1,500
- A third dental cleaning per benefit year is available for eligible members
- A no missing tooth clause is included
- You can elect to see a licensed dentist anywhere in the world
- Delta Dental has the largest network in Arizona with 3,200+ participating dentists
- You can maximize your benefits when you select a PPO Provider
- Delta Dental dentists have agreed to accept a negotiated fee (after deductibles and copays are met) and in most circumstances, cannot balance bill you more than the allowed fee
- Claims are filed by the network dentist and are paid directly, making it easier for you

To find a Delta Dental dentist near you, please visit deltadentalaz.com/find.

ID Card

New enrollees should receive a card within 10-14 business days after the benefits become effective.

When choosing between a Prepaid/DHMO plan and an Indemnity/PPO plan, you should consider the following: dental history, level of dental care required, costs/budget and provider in the Network. If you have a dentist, make sure he/she participates on the plan (Prepaid/DHMO plan – Cigna Dental or Indemnity/PPO - Delta Dental PPO plus Premier) you are considering.

Cigna Prepaid/DHMO Plan Availability

AK, MI, ME, MT, NH, NM, ND, PR, RI, SD, VT, WV and WY.



Dental Plans Comparison Chart

		CIGNA DHMO	DELTA DENTAL PPO Plus Premier
Plan Year Deductibles		None	\$50/\$150
Annual Combined Basic & Major Services		No Dollar Limit	\$2,000 per person
Orthodontia Lifetime		No Dollar Limit	\$1,500 per person
RETIREE COST FOR CARE			
PREVENTIVE CARE CLASS I	Oral Exam	\$0	\$0 - Deductible Waived ¹
	Emergency Exam	\$0 (pain treatment) \$55 (after hours office visit)	\$0 - Deductible Waived ¹
	Prophylaxis/Cleaning	\$0	\$0 - Deductible Waived ¹
	Fluoride Treatment	\$0	\$0 (to age 18) - Deductible Waived ¹
	X-Rays	\$0	\$0 - Deductible Waived ¹
Sealants		\$12 per tooth	20% (to age 19)
Fillings		Amalgam: \$0 Resin: \$0	20%
Extractions		Simple: \$12 Surgical \$53	20%
Periodontal Gingivectomy		\$91: (1 to 3 teeth) \$180: (4 or more teeth)	20%
Oral Surgery		\$12 - \$850	20%
Crowns		\$150 - \$500	50%
Dentures		\$680 upper & lower	50%
Fixed Bridgework		\$135 per unit	50%
Crown/Bridge Repair		\$43	50%
Implant Body		\$1,025	50% ²
ORTHODONTIA		Coverage for Adults & Children 24-month treatment fee (see charge schedule)	See lifetime
OTHER SERVICES	TMJ Exam/Services	\$330 Occlusal orthotic device	Not covered
	External Bleaching	\$165	Not covered

1 Routine visits, exams, and cleanings, and fluoride treatments are covered two times per Plan Year at 100%. Emergency exams are covered once per Plan Year at 100%. X-rays (Bitewing, Periapical) are covered once per Plan Year at 100%.

2 Subject to both the benefit year allowance & the lifetime maximum limit-\$1,000 per tooth. Subject to all provisions, terms and conditions of the Plan Description.

Dental Website Features

Cigna Dental Care (DHMO) mycigna.com



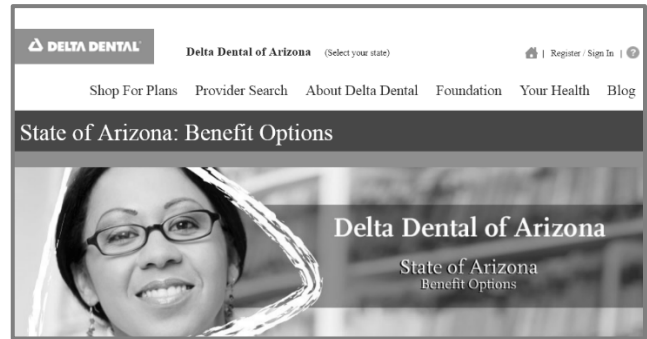
For members enrolled in the Cigna plan: visit mycigna.com, for access to:

- ☐ **Personal Profile**
You can verify your coverage, copays, deductibles, and view the status of claims.
- ☐ **ID Card**
Order a new ID card or print a temporary one.
- ☐ **Find Dentists and Services**
View office dental office features, procedures, and costs.
- ☐ **Conduct Research**
With an interactive library, you can gather information on health conditions, first aid, medical exams, wellness, and more.
- ☐ **MyCigna Mobile App**
You can download a free, personalized smart phone app. From there, you can do almost anything on the go – from getting your ID cards, account balances, locating dental providers, and so much more. Get the MyCigna Mobile app today!

Cigna Prepaid/DHMO Plan Availability

The Cigna DHMO is not available if you reside in the following states:
AK, MI, ME, MT, NH, NM, ND, PR, RI, SD, VT, WV and WY.

Delta Dental PPO plus Premier deltadentalaz.com



Delta Dental PPO plus Premier

Managing your benefits online is easy and convenient with Delta Dental! After the benefit year begins on January 1, please visit deltadentalaz.com to create your ID and password in the Member Connection, a secure website that gives you access to the following tools and materials:

View and/or print your benefits and eligibility

Go paperless and sign up for electronic Explanation of Benefits (EOBs) 24/7 claims information: Check your claims by dates, print copies of EOBs for you or your dependents, or download a claim form.

Use the Find a Dentist tool to search Delta Dental's national dentist directory

Plus:

- Download the Delta Dental Mobile App (iOS and Android) to access your ID card, view coverage and claims details, or find a dentist from your phone or tablet
- Check out the Delta Dental of Arizona Blog at deltadentalazblog.com for oral health articles and tips

Assess your risk for dental diseases with the Oral Health Assessment Tool at MyDentalScore.com/DeltaDental

Vision Plan Information

Coverage for vision is available through Avesis. Benefit Options is offering two vision care programs: Avesis Advantage Program and Avesis Discount Program.

Avesis Advantage Program

Retirees are responsible for the full premium of this voluntary plan.

Program Highlights

- Yearly coverage for a vision exam, glasses or contact lenses
- Extensive provider access throughout the state
- Unlimited discounts on additional optical purchases.

How to Use the Advantage Program

1. Find a provider – You can find a provider using the Avesis website avesis.com or by calling customer service at 1.888.759.9772. Although you can receive out-of-Network care as well, visiting an in-Network provider will allow you to maximize your vision care benefit.
2. Schedule an appointment – Identify yourself as an Avesis member employed by the State of Arizona when scheduling your appointment.

Out-of-Network Benefits

If services are received from a non-participating provider, you will pay the provider in full at the time of service and submit a claim to Avesis for reimbursement. The claim form and itemized receipt should be sent to Avesis within three months of the date of service to be eligible for reimbursement. The Avesis claim form can be obtained at the website avesis.com. Reimbursement will be made directly to the member.

Avesis Discount Program

If you do not enroll in the Advantage Program, you will automatically be enrolled in the Discounted Plan at no cost. This program will provide each member with substantial discounts on vision exams and corrective materials. No enrollment is necessary.

How to Use the Discount Program

1. Find a provider – Go to avesis.com or call customer service at 1.888.759.9772.
2. Schedule an appointment – Identify yourself as an Avesis discount card holder employed by the State of Arizona.

In-Network Benefits Only

Avesis providers who participate in the Avesis Discount Vision Care Program have agreed to negotiated fees for products and services. This allows members to receive substantial discounts on the services and materials they need to maintain healthy eyesight. Providers not participating in the program will not honor any of the discounted fees. The member will be responsible for full retail payment.

Refractive Surgery Benefit

LASIK surgery benefits are available to Advantage Program or Discount Program members. To find a LASIK provider - visit Qualsight.com/Avesis or call 1.877.712.2010.

Avesis Discount Hearing Plan

Whether you are enrolled in the Advantage Program or the Discount Program, members have access to a new Hearing Discount Plan. To utilize the Hearing Discount Plan, call 1.866.956.5400 and identify yourself as an Avesis member employed by the State of Arizona to access your benefits.

For a complete listing of covered services please refer to the plan descriptions at benefitoptions.az.gov.

	Advantage Program		Discount Program ^{1, 3}
	In-Network	Out-of-Network	
Examination Frequency	Once per Plan Year	Once every 12 months	Once per Plan Year
Lenses Frequency	Once per Plan Year	Once every 12 months	Once per Plan Year
Frame Frequency	Once per Plan Year	Once every 12 months	Once per Plan Year
Examination Copay	\$10 copay	Up to \$50 reimbursement	20% discount
Optical Materials Copay (Lenses & Frame Combined)	\$0 copay	N/A	See schedule below
Standard Spectacle Lenses			
Single Vision Lenses	Covered-in-full	Up to \$33 reimbursement	20% discount
Bifocal Lenses	Covered-in-full	Up to \$50 reimbursement	20% discount
Trifocal Lenses	Covered-in-full	Up to \$60 reimbursement	20% discount
Lenticular Lenses	Covered-in-full	Up to \$110 reimbursement	20% discount
Progressive Lenses	Uniform discounted fee schedule	Up to \$60 reimbursement	20% discount
Selected Lens Tints & Coatings	Uniform discounted fee schedule	No benefit	20% discount
Frame			
Frame	Covered up to \$100-\$150 retail value (\$50 wholesale cost allowance)	Up to \$50 reimbursement	20% discount
Contact Lenses (in lieu of frame/spectacle lenses)			
Elective	10-20% discount and \$150 allowance ²	Up to \$150 reimbursement	10-20% discount
Medically Necessary	Covered-in-full	Up to \$300 reimbursement	10-20% discount
LASIK/PRK			
LASIK/PRK	Up to \$600	Up to \$600 reimbursement	10-20% discount
¹ Members that choose not to enroll in the Advantage Vision Care Program will automatically be enrolled in the Discount Plan at no cost. ² Includes fit, follow-up and materials. ³ No out-of-network benefits for the Discount Vision Care Program.			

Vision Website Features

avesis.com/members.html.

**Login with your Employee ID Number
and create a password to have access**



Search for Providers

Search for contracted Network providers near your location.

Benefit Summary

Learn about what is covered under your vision plan and how to use your vision care benefits.

Print an ID Card

If you lose or misplace your ID card, you can print a new one.

Verifying Eligibility

You can check your eligibility status before you schedule an exam or order new materials.

Plan Policy

You can view your plan policy.

Glossary

You can learn about vision terminology.

Facts on Vision

Learn about different vision facts.

Claim Form

You can obtain an out-of-Network claim form.

International Coverage

MEDICAL CARE	
EPO Plans	
Aetna	Emergency Services Only
BCBSAZ	Emergency Services Only
Cigna	Emergency Services Only
UnitedHealthcare	Emergency Services Only
PPO Plans	
Aetna	Emergency Services Only at in-Network Benefit Level ¹
BCBSAZ	Emergency Services Only at in-Network Benefit Level ¹
UnitedHealthcare	Emergency Services Only at in-Network Benefit Level ¹
NAU Only	
Blue Cross Blue Shield PPO	For assistance with locating a provider and submitting claims call 1-800-810-2583 or 1-804-673-1686. For an international claim form bcbs.com/bluecardworldwide/index
PHARMACY	
MedImpact	Not covered
DENTAL CARE	
Prepaid/DHMO Plan	
Cigna Dental	Emergency Only
PPO Plan	
Delta Dental PPO plus Premier	Coverage is available under non-participant provider benefits
VISION CARE	
Avesis	Covered as out-of-Network and will be reimbursed based on the Avesis reimbursement schedule
<i>1 All other services should be verified by Third Party Administrator.</i>	

Long Term Disability

When receiving Long-Term Disability (LTD) benefits, for purposes of health, dental, and vision benefits, LTD members are considered “Retirees” and will fall under all premiums, processes and guidelines as retired members.

No Longer Eligible for LTD Benefits & Not Able to Retire

Your eligibility in the Benefit Options plan terminates the end of the month in which you lose eligibility. You may wish to contact your retirement system to determine if you are eligible to enroll in their health plan. It is your responsibility to notify us when your LTD entitlement ends.

Returning to Work

Your return to work will be considered a Qualified Life Event. You must make your new benefit elections within 31 days of your return to work. Please contact your agency Human Resources personnel for further instructions immediately after you lose your LTD eligibility status.

Waiver of Premiums

A Waiver of Premium only applies to life insurance and does not apply to your health, dental and vision benefits. Even if your life insurance premiums are waived, you are still responsible for payment of your medical, dental, and vision monthly premiums. Your Waiver of Premium eligibility is determined by the LTD carrier.

Please contact your LTD carrier with any questions and to learn if you are eligible for a Waiver.

Disability Benefits from Social Security & Eligibility for Medicare

If you have been receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months, you will be automatically entitled to Medicare Part A and Part B beginning the 25th month of the disability benefit entitlement. You will not need to do anything to enroll in Medicare.

Your Medicare card will be mailed to you about three months before your Medicare entitlement date. You must mail a copy of your Medicare card to the ADOA Benefit Services Division within 31 days of receiving the card.

If you are under age 65 and have a disease such as Lou Gehrig’s Disease (ALS), you will be entitled to Medicare the first month you receive disability benefits from Social Security or the Railroad Retirement Board. For more information, call the Social Security Administration at 1.800.772.1213.

Receiving Social Security Disability

The Benefit Options health plans require all Medicare eligible members to enroll in both Part A (hospital insurance) and Part B (medical insurance). For more information, contact the Social Security Administration or the ADOA Benefit Services Division.

Legal Notices

General COBRA Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other Members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefit Services Division.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee become entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child"

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Benefit Options Plan, and that bankruptcy results in a loss of coverage of any Retired Employee covered under the Plan, the Retired Employee will become a qualified beneficiary. The Retired Employee's Spouse, Surviving Spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Health Insurance Marketplace Coverage Options & Your Health Coverage

General Information

When key parts of the health care reform law (the Affordable Care Act or ACA) take effect in 2014, there will be a new way to buy health insurance: through the health insurance marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new marketplaces and employment based health coverage offered by your employer.

What is the health insurance marketplace?

The marketplace is designed to help you find health insurance that meets your needs and fits your budget. The marketplace offers "one-stop shopping" to find and compare private health insurance options. You can enroll for health insurance coverage through the Marketplace during an enrollment period that begins in October 2013. Coverage can begin as early as January 1, 2014.

Can I save money on my health insurance premiums in the marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Market place and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.69% of your household income for that year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the marketplace instead of accepting health coverage offered by your employer, then you will lose any employer contribution to the State of Arizona Benefit Options Plan.

Also, this employer contribution – as well as your employee contribution to State of Arizona Benefit Options Plan – is often excluded from income for Federal and State income tax purposes. Future enrollment in the State of Arizona Benefit Options Plan will be limited to open enrollment (which typically happens in the fall).

How can I get more information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Arizona Department of Administration Benefit Services Division contact information included in employer information chart.

The marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. Visit www.HealthCare.gov for more information, including an online application for health insurance coverage and a Health Insurance Marketplace in your area.

Information about health coverage offered by your employer

If you decide to complete an application for coverage in the marketplace, you will be asked to provide the information included in the chart below. This employer information is numbered to correspond to the marketplace application.

Employer Information - Numbers Correspond to the Marketplace Application	
3. Employer Name	State of Arizona
4. Employer Identification Number (EIN)	86-6004791
5. Employer Address	100 N 15 th Ave, Suite 260
6. Employer Phone Number	(602) 542-5008
7. City	Phoenix
8. State	AZ
9. Zip Code	85007
10. Who can we contact about employee health coverage at this job?	Benefit Services Division
12. E-mail Address	BenefitsIssues@azdoa.gov

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to some employees and dependents. Eligible employees and dependents are defined in the EPO, PPO and HSA plan descriptions (Article 3 Eligibility and Participation) posted on the Benefit Options website www.benefitoptions.az.gov
- This coverage provided meets the minimum value standard, and the cost of this coverage is intended to be affordable.

If you decide to shop for coverage in the marketplace, www.HealthCare.gov will guide you through the process. The employer information you can enter when you visit www.HealthCare.gov will help you determine if you can get a subsidy (in the form of a tax credit) to lower your monthly premiums for coverage purchased through the marketplace.

Newborns' and Mothers' Protection Act of 1996

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or a physician assistant), after consultation with the mother, discharges the mother or her newborn earlier. Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. If you have any questions, contact Benefit Options at 602 542 5008 or 1 800 304 3687 or email Benefit Options at BenefitIssues@azdoa.gov.

Nondiscrimination Notice

Benefit Options complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Benefit Options provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, contact:

ADOA Benefit Services Division
100 N. 15th Avenue, Suite 260
Phoenix, AZ 85007
602-542-5008 or 1-800-304-3687, or email BenefitIssues@azdoa.gov

If you believe that we have failed to provide these services or discriminated based on a protected class noted above, you can also file a grievance with ADOA Benefit Services Division.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 602-542-5008 or 1-800-304-3687.

Díí BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánitti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 602-542-5008 or 1-800-304-3687 hodíłnih.

Patient Protection & Affordable Care Act (PPACA)

Notice of Rescission

Under the PPACA, Benefit Services Division cannot retroactively cancel or terminate an individual's coverage, except in cases of fraud and similar situations. In the event that the Benefit Services Division rescinds coverage under the allowed grounds, affected individuals must be provided at least 30 days advanced notice.

Form W-2 Notice

Pursuant to the PPACA for tax years starting on and after January 1, 2012, in addition to the annual wage and tax statement employers must report the value of each employee's health coverage on form W-2, although the amount of health coverage will remain tax-free.

Notice about the Summary of Benefits and Coverage (SBC) and Uniform Glossary

On February 9, 2011, as part of the Affordable Care Act (ACA), the federal government announced new rules regarding the disclosure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary. These regulations require group health plans and health insurance issuers that offer coverage for groups and individuals to provide access to the SBC and Uniform Glossary effective October 22, 2012. The SBC documents along with the uniform glossary will be posted electronically to the Benefit Options Website www.benefitoptions.az.gov. You may also contact Benefit Services to obtain a copy.

Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage through the Benefit Options program and about your options under Medicare's prescription drug coverage. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage: Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

ADOA has determined that the prescription drug coverage offered by the Benefits Options Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare Drug Plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Benefit Options coverage will be affected. If you enroll in a Medicare Part D Plan, you will not be eligible for Benefit Options medical coverage.

If you do decide to join a Medicare drug plan and drop your current Benefit Options coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Benefit Options and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.

You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

For further information contact ADOA Benefit Services Division at 1.800.304.3687 or visit our website at www.benefitoptions.az.gov. Questions can also be sent to ADOA Benefit Services Division via email at BenefitIssues@azdoa.gov.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if the coverage through Benefit Options changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov;
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help;
- Call 1-800-MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

HIPAA Privacy Regulation Requirements

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to allow the Disclosure of Protected Health

Information (PHI) as defined under HIPAA, to the Plan Sponsor and other parties as necessary to determine appropriate processing of claims.

Special Enrollment Rights for Health Plan Coverage

If you decline enrollment in the State of Arizona's health plan for you or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you or your Dependents may be able to enroll in the State of Arizona Employee's health plan without waiting for the next Open Enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new Dependent as a result of marriage, birth, adoption or placement for adoption. You must request health plan enrollment within 31 days after the marriage birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the State of Arizona's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your Dependent becomes eligible for special enrollment rights, you may add the Dependent to your current coverage or change to another health plan.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because the Plan health plan offers coverage for mastectomies, WHCRA applies to the Plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the Plan.

Glossary

Appeal

A request to a plan provider for review of a decision made by the plan provider.

Balance Billing

A process in which a member is billed for a provider's fee that remains unpaid by the insurance plan. You should never be balance billed for an in-Network service; out-of-Network services and non-covered services are subject to balance billing.

Beneficiary

The person(s) you designate to receive your life insurance (or other benefit) in the event of your death.

Brand Name Drug

A drug sold under a specific trade name as opposed to being sold under its generic name. For example, Motrin is the brand name for ibuprofen.

Case Management

A process used to identify members who are at risk for certain conditions and to assist and coordinate care for those members.

Centers for Medicare & Medicaid Services (CMS)

The Federal agency that administers Medicare. You may contact Medicare at 1.800.MEDICARE (1.800.633.4227) or medicare.gov.

Claim

A request to be paid for services covered under the insurance plan. Usually the provider files the claim but sometimes the member must file a claim for reimbursement.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

A federal law that requires larger group health plans to continue offering coverage to individuals who would otherwise lose coverage. The member must pay the full premium amount plus an additional administrative fee.

Coinsurance

A percentage of the total cost for a service/prescription that a member must pay after the deductible is satisfied.

Coordination of Benefits (COB)

An insurance industry practice that allocates the cost of services to each insurance plan for those members with multiple coverage.

Copay

A flat fee that a member pays for a service/prescription.

Coverage Gap (Donut Hole)

Medicare GenerationRX for Benefit Options does not have a donut hole. You will continue to pay the same cost sharing throughout the plan year.

Creditable Coverage

Prescription drug coverage (for example, from an employer) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Deductible

Fixed dollar amount a member pays before the health plan begins paying for covered medical services. Copays and/or coinsurance amounts may or may not apply. (See comparison charts on pg. 20).

Dependent

An individual other than a health plan subscriber who is eligible to receive healthcare services under the subscriber's contract. Refer to pg. 5 for eligibility requirements.

Disease Management

A program through which members with certain chronic conditions may receive educational materials and additional monitoring/support.

Disenrollment

The process of ending your membership in Benefit Options medical and pharmacy plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Tier

Every drug on the list of covered drugs (formulary) is in a drug tier. In general, the higher the drug tier, the higher your cost for the drug.

Emergency

A medical or behavioral condition of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the insured person in serious jeopardy, serious impairment to bodily functions, serious disfigurement of the insured person, serious impairment of any bodily organ or part of the insured person, or in the case of a behavioral condition, placing the health of the insured person or other persons in serious jeopardy.

EPO (Exclusive Provider Organization)

A type of health plan that requires members to use in-Network providers.

Exclusion

A condition, service, or supply not covered by the health plan.

Explanation of Benefits (EOB)

A statement sent by a health plan to a covered person who files a claim. The explanation of benefits (EOB) lists the services provided, the amount billed, and the payment made. The EOB statement must also explain why a claim was or was not paid, and provide information about the individual's rights of appeal.

Formulary

The list that designates which prescriptions are covered and at what copay level.

Generic Drug

A drug which is chemically equivalent to a brand name drug whose patent has expired and which is approved by the Federal Food and Drug Administration (FDA).

Grievance

A written expression of dissatisfaction about any benefits matter other than a decision by a plan provider.

ID Card

The card provided to you as a member of a health plan. It contains important information such as your member identification number.

Income Related Monthly Adjustment Amount (IRMAA)

Individuals with income greater than \$85,000 and married couples with income greater than \$170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income related monthly adjustment amount.

Late Enrollment Penalty

An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount if you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help" you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

Low Income Subsidy (LIS)

A program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Long-Term Disability

A type of insurance through which you will receive a percentage of your income if you are unable to work for an extended period because of a non-work-related illness or injury.

Mail-Order Pharmacy

A service through which members may receive prescription drugs by mail.

Medically Necessary

Services or supplies that are, according to medical standards, appropriate for the diagnosis.

Medicare

The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan and prescription drug coverage through a Medicare Advantage Prescription Drug plan (MA-PD) or a stand-alone Prescription Drug Plan (PDP) that works with Original Medicare.

Member

A person who is enrolled in the health plan.

Member Services

A group of employees whose function is to help members resolve insurance-related problems.

Network

The collection of contracted healthcare providers who provide care at a negotiated rate.

Out-of-Pocket Maximum

The annual amount the member will pay before the health plan pays 100% of the covered expenses. Out-of-pocket amounts do not carry over year to year.

Over-the-Counter (OTC) Drug

A drug that can be bought without a prescription.

Part D Drugs

Drugs that can be covered under Part D. We may or may not offer all Part D drugs (see your formulary for a specific list of covered drugs). Certain categories of drugs were specially excluded by Congress from being covered as Part D drugs.

PPO (Preferred Provider Organization)

A type of health plan that allows members to use out-of-Network providers but gives financial incentives if members use in-Network providers.

Pre-Certification/Prior Authorization

The prospective determination performed by the Medical Vendor to determine the medical necessity and appropriateness of a proposed treatment, including level of care and treatment setting.

Preventive Care

The combination of services that contribute to good health or allow for early detection of disease.

Choice90RX Retail Pharmacy

A program that allows members to get up to a 90-day supply of covered prescription drugs from a participating retail pharmacy.

Social Security Administration

The Federal agency that determines, among other things, whether you are entitled to and eligible for Medicare benefits.

Specialty Drugs

High-cost drugs that are used to treat complex conditions, such as anemia, cancer, hepatitis C, and multiple sclerosis, and that usually require injection and special handling. Plans can include these drugs in a separate "specialty" drug tier if their cost is above an amount specified by Medicare.

Usual and Customary (UNC) Charges

The standard fee for a specific procedure in a specific regional area.

Contact Information

Benefit Options	ADOA Benefit Services Division 100 N. 15th Avenue, Suite 260 Phoenix, AZ 85007	602-542-5008 800-304-3687	benefitoptions.az.gov
Medical Plans	Aetna	866-217-1953	aetnastateaz.com
	Blue Cross Blue Shield of AZ	866-287-1980	azblue.com
	Cigna	800-968-7366	cigna.com/stateofaz
	UnitedHealthcare	800-896-1067	stateofazwelcometouhc.com
Pharmacy Plans	MedImpact	888-648-6769	benefitoptions.az.gov
	Medicare GenerationRx Employer PDP	877-633-7943	medicaregenerationrx.com/stateofaz
Dental Plans	Cigna	800-968-7366	cigna.com/stateofaz
	Delta Dental of Arizona	602-588-3620 866-9STATE9	deltadentalaz.com
Vision Plan	Avesis, Inc.	888-759-9772	avesis.com
Retirement Systems	Arizona State Retirement System (ASRS) 3300 N. Central Ave, Lobby Phoenix, AZ 85012	602-240-2000 800-621-3778	azasrs.gov
	<ul style="list-style-type: none"> Public Safety Personnel Retirement System (PSPRS) Elected Officials Retirement Plan (EORP) Corrections Officer Retirement Plan (CORP) 3010 E. Camelback Rd, #200 Phoenix, AZ 85016	602-255-5575 877-925-5575	psprs.com
Wellness (Flu Shots Only)	ADOA Benefit Services Division 100 N. 15th Avenue, Suite 260 Phoenix, AZ 85007	602-771-9355	benefitoptions.az.gov/wellness